PUBLIC HEALTH COUNCIL

Meeting of the Public Health Council, Tuesday, July 22, 2003, 10:00 a.m., Massachusetts Department of Public Health, 250 Washington Street, Boston, Massachusetts. Public Health Council Members present were: Acting Chair Janet Slemenda, Mr. Manthala George, Jr.,and Ms. Shane Kearney Masaschi. Chairman Christine Ferguson and Ms. Maureen Pompeo participated by a conference call via a speaker telephone. Mr. Albert Sherman, Dr. Thomas Sterne, Dr. Martin Williams and Ms. Phyllis Cudmore were absent. Attorney Donna Levin was present as General Counsel.

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Acting Chair Janet Slemenda made the following announcements: (1) that notices of the meeting had been filed with the Secretary of the Commonwealth and the Executive Office of Administration and Finance, in accordance with the Massachusetts General Laws, Chapter 30A, Section 11A ½; (2) that the meeting will be held in compliance with said Chapter 30A, when a quorum is obtained via speaker telephone. Due to scheduling conflicts, a quorum did not exist for the beginning of the meeting, consequently, items 2A through 2C, which require a vote, had been moved to the end of the agenda. Informational items such as the staff presentation and the proposed regulation were heard at the beginning of the meeting (no vote required).

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The following members of the staff appeared before the Council to discuss and advise on matters pertaining to their particular interests: Ms. Anne Sheetz, Director of School Health Services; Atty. Howard Saxner, Deputy General Counsel, Office of the General Counsel; and Dr. Paul Dreyer, Director, Division of Health Care Quality.

PERSONNEL ACTIONS:

In a letter dated July 7, 2003, Katherine Domoto, M.D., Associate Executive Director for Medicine, Tewksbury Hospital, Tewksbury, recommended approval of the appointment of Ronald Pies, M.D. to the consultant medical staff of Tewksbury Hospital. Supporting documentation of the appointee's qualifications accompanied the recommendation. After consideration of the appointee's qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Associate Executive Director for Medicine of Tewksbury Hospital, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the appointment of Ronald Pies, M.D. to the medical staff of Tewksbury Hospital be approved for a period of two years beginning July 1, 2003 to July 1, 2005:

APPOINTMENT	STATUS/SPECIALTY	MEDICAL LICENSE NO.

Ronald Pies, M.D.	Consultant/Psychiatry	53662

In a letter dated July 14, 2003, Paul D. Romary, Executive Director, Lemuel Shattuck Hospital, Jamaica Plain, recommended approval of initial appointments and reappointments to the various medical staffs of Lemuel Shattuck Hospital. Supporting documentation of the appointees' qualifications accompanied the recommendation. After consideration of the appointees' qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Executive Director of Lemuel Shattuck Hospital, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the initial appointments and reappointments to the various medical staffs of Lemuel Shattuck Hospital be approved as follows:

APPOINTMENTS	**STATUS/SPECIALTY**	**MEDICAL LICENSE NO.**
Michael Angelis, M.D.	Consultant/Surgery	206095
Mayana Golumb, M.D.	Consultant/Psychiatry	80710

REAPPOINTMENTS	**STATUS/SPECIALTY**	**MEDICAL LICENSE NO.**
Michael Gregory, M.D.	Consultant/Internal Medicine	20855
Sidhartha Pani, M.D.	Consultant/Internal Medicine/Nephrology	202636
Aaron Greenwald, M.D.	Consultant/Psychiatry	212692
George Whitelaw, M.D.	Active/Orthopedic Surgery	34608

In a letter dated July 10, 2003, Blake M. Molleur, Executive Director, Western Massachusetts Hospital, Westfield, recommended approval of the appointments and reappointment of physicians to the consulting medical staff of Western Massachusetts Hospital. Supporting documentation of the appointees' qualifications accompanied the recommendation. After consideration of the appointees' qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Executive Director of Western Massachusetts Hospital, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the following appointments and reappointment to the consulting medical staff of Western Massachusetts Hospital be approved:

APPOINTMENTS	**STATUS/SPECIALTY**	**MEDICAL LICENSE NO.**
Tedd Ackerman, M.D.	Psychiatry	78810
Jaffe Kenneth, M.D.	Psychiatry	47691

REAPPOINTMENT	**STATUS/SPECIALTY**	**MEDICAL LICENSE NO.**

Paul Haley, M.D. Psychiatry/Consulting 81763

STAFF PRESENTATION:

"MATERNAL OUTCOMES AT MASSACHUSETTS HOSPITALS AND MASSACHUSETTS EMERGENCY DEPARTMENT DATA", by Amy Lischko, Co-Director, Division of Health Care Finance and Policy (DHCFP) and Kathleen Kerwin Fuda, Ph.D., Manager, Data Initiatives and Analysis, (DHCFP)

Ms. Amy Lischko, Co-Director, Division of Health Care Finance and Policy (DHCFP), presented "Maternal Outcomes at Massachusetts Hospitals". She said, "…Today, we are going to report on maternal outcomes in Massachusetts hospitals, a recent study that was conducted by the Division of Health Care Finance and Policy. The data suggests that there is very little difference in the maternal outcomes between teaching and community hospitals. Our research objective was to assess maternal outcomes associated with routine or low risk deliveries at community and teaching hospitals in Massachusetts. Why do we study maternal outcomes between teaching and community hospitals? For several different reasons:

- Massachusetts residents use teaching hospitals more often than residents of other states use teaching hospitals. In fact, recent data suggests that Massachusetts residents use teaching hospitals three times more often than residents of other states.

- Care for comparable conditions is typically more expensive at teaching hospitals. Charges for vaginal births in this study were two times higher in teaching hospitals, while charges for C-sections were seventy-five percent higher.

- Many women delivering at Boston hospitals live elsewhere. These data show that two-thirds of women delivering at Boston hospitals live in zip codes outside the city limits presumably passing by community hospitals that offer maternity services.

- There is very little comparative data on clinical quality that are available to consumers and purchasers, and we really wanted to begin a dialogue around this subject. Here is some data that shows the shift from community to teaching hospitals for deliveries. In 2001, compared to 1992 ,community hospitals performed twenty-four percent fewer deliveries, while teaching hospitals performed thirty-eight percent more.

- Ms. Lischko continued, "Out study design used for this study was an analysis that modified a study reported on in "Obstetrics and Gynecology". This study that we looked at was conducted using data from Maryland hospitals, and it was reported on in the New York Times a little over a year ago. This is what sparked our interest in repeating this study for Massachusetts hospitals. The clinical outcome measures that we looked at in this study included primary and repeat C-section rates, total laceration rates, which included episiotomies and lacerations, and complication rates. We used a multiple logistic regression analysis that adjusted for the following variables; age, number of diagnoses, payer source, race, presence of substance abuse, the type of delivery and the possible maternal volume at

the hospital. Our study population included fiscal year 2000 and 2001 hospital discharge records and they were selected by diagnostic related groups, or DRGs, for non-high risk deliveries. The high risk deliveries accounted for about four percent of all deliveries in Massachusetts, and those are excluded from this analysis. The two year study used a hundred and fifty-two thousand, nine hundred and thirty-eight records, and teaching hospitals were defined as either sponsoring obstetrics residency or being a major participating institution in such a residency."

Ms. Lischko, noted, "Our findings from this study are as follows: After adjustment, the likelihood of primary and repeat C-sections were not statistically different between teaching and community hospitals. In addition, total laceration rate, which included episiotomy and laceration repair, was not statistically different by teaching and community hospitals. And finally, the complication rate was significantly higher at teaching hospitals, but the difference was small. As with any study, there are always limitations or qualifications to the data and to the research, and I just wanted to briefly mention a few of the more important ones. This study assessed only maternal outcomes. We understand that it would also be very important to look at the outcomes of the infants. Women would be very interested in this, as they should be, and we would like to do some follow-up work in that area. This analysis used only outcome measures that are readily available in administrative files. There is always a limitation when you look at quality or outcomes, and the time that it takes to use data other than administrative data files is always a burden. We wanted to begin a dialogue, and we felt that using our administrative data files, as was done in the Maryland study, was enough to begin this dialogue. We may not have been able to adequately adjust for confounding variables. There may be patient characteristics that are related to the outcomes, that aren't available in the administrative files."

In conclusion, Ms. Lischko, stated, "This study found that, for low risk deliveries, maternal outcomes were comparable for community and teaching hospitals. However, we believe that direct application of these results to actually change where low risk women obtain maternity care may not be straightforward, and this is true for a number of reasons, which are talked about more deeply in the study itself. But one of the more important reasons is the distribution of community hospitals and teaching hospitals in Massachusetts, there actually are no options for women who live in the city for delivering at a community hospital at this time."

NO VOTE/INFORMATION ONLY

Ms. Kathleen Kerwin Fuda, Ph.D, Manager, Data Initiatives and Analysis, DHCFP, made a presentation on the database created at the Division of Health Care Finance and Policy. She said in part, "…Our new Emergency Department database includes full reporting on outpatient ED visits starting in October 1, 2001. We have retrospective data back to January 1, 2000. That is a somewhat more limited set of data elements that were required, although many hospitals were able to report anyway. Currently, it has well over six million visit records for 2000 through early 2003, and some of the data that I am going to present today includes data on admitted ED patients, and that is drawn from our inpatient and observation stay databases, though we did add flags to those databases so that we could clearly identify which of those patients had come through the ED. When we look at ED visit volume trend, we noticed a couple of things. First, there is a general, overall increase in volume from 2000 through 2002, but you also notice a

distinct seasonal pattern with peaks in the summer because Q4 covers July through September, and each year – there is a wave pattern there. We have variation in volume by day of the week with Saturday and Sunday, and particularly Monday being the busiest days. We look at other variations. We look at time of day. This measures the time at which the patient was registered. The thick purple line is going to be overall volume in the ED, and you can see that it peaked through the late afternoon, early evening hours. What we found interesting was that there was really quite a distinct pattern as to when different age groups come to the ED. The elderly come-in during the morning or early afternoon hours; whereas, children tend to come-in later in the day, perhaps after school, after parents are home from work – that was one advantage of our data system that we hadn't thought about before."

Ms. Kerwin Fuda continued, "In terms of what the disposition of patients are, about 83 percent of all ED patients are considered outpatients. In other words, they are discharged home. They may be transferred to some other facility, but they are not admitted at that hospital. About 15 percent are admitted as inpatient, and then another 2 percent are admitted to an observation stay. This visit disposition rate varies tremendously by age, as one might expect. The elderly have much higher rates of being admitted to inpatient care. If we look at it by age, you see just a little under one-third of all ED patients are between twenty-five and forty-four years of age. Children are 15 or 16 percent. About the same amount are adolescent or young adults. The older middle age, about 20 percent; 18 percent are elderly. Injuries are by far the most common reason for an outpatient ED visit. This is looking at the primary diagnosis as it was given to us. About 17 percent are in the category symptoms, signs and ill-defined conditions, which just means there isn't anywhere to fit it in, the diagnosis given…About half of outpatient ED visits are covered by private insurance. Also of interest here is the Free Care and Self-Pay. That does seem high given the estimate of the uninsured in the state in 2002, about 6.7 percent. We looked at the visit rate by race and ethnicity, and it shows Black and Hispanic patients have much higher visit rates than white patients, and for comparison we included our inpatient. This is all inpatient discharges, just to show what the variation by race is in our inpatient data…This is an overall distribution of what the charges are. This is a curve shape that is familiar to us from our inpatient data. It looks very similar; although, the absolute numbers are of course, much lower in the Emergency Department setting, that the mean charge was about six hundred and sixty-seven dollars in 2002. The Emergency Department data includes detailed information on what services were provided to patients, and so this is using that data that is basically just counting how many services we provided to patients. We have mean charge data as you can see, the age of the patient goes up, so do the charge increases and, as you would expect, the number of services provided to those patients go up."

In summary, Ms. Kathleen Kerwin, stated, "The ED visit volume increased over the fiscal years 2000 through 2002. The visit volume varies by time of day, by time of week, and also by the season of the year. Evenings are busiest. Saturdays through Monday are busiest, and summers are busiest. Patients of different ages tend to use the ED at very different periods of the day. Kids come in late. The elderly and older, middle aged folks tend to come in during daytime hours. There are distinct racial differences in the outpatient ED utilization rates. Blacks and Hispanics have higher rates than Whites. Injuries are the most important cause of visits to the Emergency Departments. ED service use, charges and admit rates all increase with age, and the uninsured account for a disproportionately large percent of outpatient ED visits. And we have

really only recently begun serious analysis of the data since the files have been gathered, but next we would like to examine issues about access to primary care services using the emergency department data…looking at the health care system, looking at overcrowding and capacity in EDs, looking at the content of care in more detail. For instance, we can look at what diagnostic tests are being ordered…what drugs are being prescribed…We are interested at looking at particular populations such as children, elderly, or the uninsured or groups that have a particular diseases, like diabetes or mental health issues."

NO VOTE INFORMATION ONLY

PROPOSED REGULATIONS: INFORMATIONAL BRIEFING ON PROPOSED AMENDMENTS TO REGULATIONS GOVERNING ADMINISTRATION OF PRESCRIPTION MEDICATIONS IN PUBLIC AND PRIVATE SCHOOLS – 105 CMR 210.000:

Ms. Anne Sheetz, Director of School Health Services, accompanied by Attorney Howard Saxner, Deputy General Counsel, presented the proposed school regulations 105 CMR 210.000 to the Council. Staff noted the following reasons for the proposed regulations:

- Increased numbers of children with identified life-threatening allergies are attending schools. In the 1995-96 school year, data indicated 3.8 to 4.4 Epi-pens prescribed per thousand students per month. In the 1996-97 school year, the reported rate rose to 4.4 to 4.9 per thousand. In the 2000-2001 school year, school districts reported 7.2 epinephrine prescriptions per thousand students. During the 2001-2002 school year the rate rose to 8.3 prescriptions per thousand students.

- In the past two school years, under a voluntary reporting system, more than 100 students in Massachusetts were given epinephrine in an emergency. Some of these incidents occurred in before and after school programs.

- The current regulations permit unlicensed personnel to administer epinephrine in a school (provided the school is registered with the Department for this purpose), but are limited in scope to the school day.

- Epinephrine is the drug of choice for emergency management of a child experiencing a potentially life-threatening allergic reaction. Fatalities may occur when epinephrine is withheld or delayed.

- In the absence of regulations governing before and after school programs, practices vary widely from school to school, and administration by unlicensed personnel has no legal sanction.

- The proposed regulations provide school officials, parents, health professionals, and educational personnel with the guidance necessary to guarantee safe and proper

administration of epinephrine in before and after school programs.

- The proposed regulations help implement recommendations contained in guidelines entitled, "Managing Life-Threatening Food Allergies in Schools," published in September, 2002 by the Massachusetts Department of Education, and developed in collaboration with the Massachusetts Department of Public Health, the Asthma and Allergy Foundation, New England Chapter, and others.

Staff noted further, "The proposed amendments set uniform standards for safe and proper administration of epinephrine by trained, unlicensed personnel to students in before and after school programs, provided the school or school district is registered with the Department for this purpose. The regulations require that the school committee (or chief administrative officer in a non-public school) approve a policy for administration of epinephrine in before and after school programs. The regulations require that the individual(s) responsible for the program, in consultation with the designated school nurse leader or responsible school nurse, specify which before and after school programs are to be covered by the policy. In addition, if the policy so provides, epinephrine may be administered to a student visiting from another school or school district, provided that certain requirements are met. In addition, the regulations:

- Require epinephrine to be stored in such a manner as to allow rapid access by authorized persons;

- Require submission of a written report to the Department of Public Health each time epinephrine is administered;

- Clarify that the administration of parenteral medications may not be delegated to unlicensed personnel, with the exception of epinephrine administered in accordance with 105 CMR210.100."

In closing, Staff said, "Department staff plan to proceed to public hearing on the proposed amendments to the Regulations Governing the Administration of Prescription Medications in Public and Private Schools and to return to the Public Health Council for final approval in the beginning of the school year."

NO VOTE/INFORMATION ONLY

The meeting adjourned at 11:45 a.m.

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Christine C. Ferguson
Chair

LMH/lmh